

**FILED** DES 06 1945

Registration District No. \_\_\_\_\_

Primary Registration District No. 5103

Registrar's No. 26

1. PLACE OF DEATH:

(a) County Benton  
 (b) City or town Warsaw Mo  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
 In this community 10 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Benton  
 (c) City or town Warsaw Mo "Rural"  
(If outside city or town limits, write "RURAL")  
 (d) Street No. RR #1 (If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME JOSEPH P. LAMBERT

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race white  
 6. (a) Single, widowed, married, divorced wid  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive deceased years  
 7. Birth date of deceased Feb 17 1864  
(Month) (Day) (Year)

8. AGE: Years 81 Months 9 Days 28 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Warren Mo Ill.  
(City, town, or county) (State or foreign country)

10. Usual occupation retired farmer

11. Industry or business

12. Name Jacob Lambert  
 13. Birthplace Veri Ill.  
(City, town, or county) (State or foreign country)  
 14. Maiden name Sarah Lindsey  
 15. Birthplace Veri Ill.  
(City, town, or county) (State or foreign country)

16. (a) Informant Devere Lambert  
 (b) Address Warsaw Mo RR #1

17. (a) Removal (b) Date thereof 11-16-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Englewood

18. (a) Signature of funeral director Charles Beck  
 (b) Address Chantagon

19. (a) 11-19-45 (b) Jas. T. Logau  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Nov day 15  
 year 1945 hour 9 PM minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from never 19 \_\_\_\_\_ to never 19 \_\_\_\_\_  
 that I last saw him alive on never 19 \_\_\_\_\_  
 and that death occurred on the date and hour stated above

Immediate cause of death accidental burn  
 Due to house burning

Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy 1876

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) accident  
 (b) Date of occurrence 11-15-1945  
 (c) Where did injury occur Warsaw Benton Mo  
(City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?  
in home on farm  
 While at work? \_\_\_\_\_ (Specify type of place)  
 (e) Means of injury \_\_\_\_\_

23. Signature D. Devere (Coroner) M. D. or other) 3  
 Address Cole Camp Mo Date signed 11-16-45

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECORDED  
C  
No. 7,  
Disc. 11-45-1149  
Date Filed 12-4-45

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No. ....

working under my personal supervision.

Signed J. E. Consoled  
Licensed Embalmer No. 1891

P. O. Address Clinton Mo.

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

If this body is not embalmed, fact should be so stated above.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. Dec26Registration District No. 30Primary Registration District No. 510 31Registrar's No. 26

## 1. PLACE OF DEATH:

- (a) County Benton  
 (b) City or town Warsaw Rural Lindbergh  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
 In this community \_\_\_\_\_ years, months or days)

3. (a) PRINT  
FULL NAMEJoseph P. Lambert3. (b) If veteran  
name war \_\_\_\_\_3. (c) Social Security  
No. \_\_\_\_\_

4. Sex m 5. Color or race w 6. (a) Single, widowed, married  
divorced wid  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if  
alive \_\_\_\_\_  
 7. Birth date of deceased Feb. 17  
 (Month) (Day) (Year)

8. AGE: Years 81 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day  
hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

## 10. Usual occupation

## 11. Industry or business

12. Name \_\_\_\_\_  
 13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) Virginia  
 14. Maiden name \_\_\_\_\_  
 15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) Gas & Logan  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
 (c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_ (If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_  
year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M.21. I hereby certify that I attended the deceased from \_\_\_\_\_  
to \_\_\_\_\_, 19\_\_\_\_;that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

## PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged sta-  
tistically.

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
 (b) Date of occurrence \_\_\_\_\_  
 (c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?  
 \_\_\_\_\_ (Specify type of place)  
 While at work? \_\_\_\_\_ (c) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

365713